Recognizing Mental Illness in the Courtroom

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Objective

- Judges will be able to identify persons in their courts who have a serious mental illness which may affect the court proceedings or the resolution of the case.
- Judges will learn legal options for management of people with mental illness in court.

Why are we doing this session?

- We both have experience with people who are seriously mentally ill, in the clinical setting and in court.
- We both would like to see the mentally ill person in court be dealt with in a more knowledgeable manner.
- We both would like to see judges be more comfortable and confident in cases with a person who is seriously mentally ill.

What are our qualifications?

- Judge Collins
- Dr. Parker

Forensic Psychiatry

- Major Roles:
  - Psychiatric evaluations of people involved with the legal system.
  - Psychiatric treatment of people in jails, prisons or forensic hospitals.

“Me? I’m just one of those shadowy figures who inhabit the mysterious world where the medical and legal professions meet.”

When does mental illness matter?

- If the person in court is not exhibiting inappropriate behavior, it might not matter whether he/she has a mental illness!
- If the behavior or statements are inappropriate, will it affect the outcome of the case?
  - Some cases may be actually be part of the person's serious mental illness.

Why would you want to know?

- Mental illness may determine how the case will proceed:
  - Diversion programs
    - Crisis intervention training (CIT) teams
    - Referral to treatment
    - Post-conviction treatment requirement
  - Competence to stand trial.
  - Not guilty by reason of insanity.

What should you look for?

- Serious mental illness comes in a variety of forms.

Common Mental Disorders

- Mood Disorders
  - Depression, Bipolar Disorder
- Psychotic Disorders
  - Schizophrenia
  - Substance-induced
- Personality Disorders
  - Antisocial
  - Borderline

Common Child Mental Disorders

- Disruptive disorders
  - Conduct
  - Oppositional-defiant
  - Attention deficit hyperactivity

Depression

- A common disorder:
  - At any given time, 2% of men and 5% of women are clinically depressed.
- with serious consequences:
  - 15% risk of suicide
- and biological underpinnings:
  - changes in brain neurochemistry.
- that is often recurrent.

Characteristics of Depression

- Consistently depressed mood and loss of interest in activities for more than two weeks, along with:
  - Decreased appetite, sleep and/or energy.
  - Decreased concentration.
  - Feelings of worthlessness.
  - Thoughts of death or suicide.

Depression in Court

- A depressed defendant will:
  - Move slowly
  - Talk little and in a monotone
  - Won’t care what’s going on
  - Show little emotion
  - Avoid eye contact
  - Show a slumped posture

Treatment of Depression

- Antidepressant medication is a mainstay.
- Psychotherapy is also very useful.

Bipolar Disorder

- Less common than depression, but more disruptive.
  - Lifetime prevalence is ~1%.
- Characterized by manic episodes, which often occur just before or after a depressive episode.
- 10% risk of suicide.
- Strongly recurrent; runs in families.

Mania

- One week or more of an abnormally elevated, expansive or irritable mood, accompanied by:
  - High energy levels and little need for sleep,
  - Racing and disorganized thoughts, rapid speech, easy distractibility, and
  - Impulsive involvement in risky behavior.
  - Psychosis may occur in later stages.

Mania in Court

- Agitated, unable to sit still or keep quiet.
- Ignores advice of attorney or judicial directions; often interrupts.
- Speaks rapidly, loudly and on many topics at once.
- Vibrantly dressed, often disheveled.

Treatment of Bipolar Disorder

- Medication management is critical.
- Mood-stabilizing medication:
  - Lithium and Depakote are common.
- Antipsychotic medication:
  - Seroquel, Geodon, Zyprexa, Risperdal, Abilify
  - Agitation and psychosis
- Bipolar depression can be hard to treat.

Schizophrenia

- ~1% lifetime prevalence among adults.
- Onset in early adulthood.
- A chronic disorder, characterized by symptoms of psychosis.
- 10% risk of suicide.
- Strong genetic and biologic components.

Symptoms of Psychosis

- Delusions: fixed, false beliefs.
  - Paranoia is common.
- Hallucinations: usually auditory or visual.
- Disorganized speech.
- Disorganized behavior.
- Negative symptoms:
  - decreased speech, emotion, motivation.

Schizophrenia in Court

- A wide range of possible presentations:
- Paranoid: angry, accusatory, often quite coherent.
- Disorganized: disheveled, confused, mumbling.
- Negative symptoms: slow-moving, detached, uncaring, unkempt.

Treatment of Schizophrenia

- Antipsychotic medication is very important.
- Social supports can be critical to effective functioning in the community.
  - Case management
  - Assertive Community Treatment (ACT) teams

Drug-induced Psychosis

- Some drugs of abuse can make people quite agitated and psychotic during intoxication and withdrawal; some may cause persistent damage.
- Intoxication: cocaine, inhalants, LSD, opiates, PCP, methamphetamine, ‘wet’.
- Withdrawal: alcohol.
- Persistent: inhalants, PCP, ‘wet’, alcohol

Drug Psychosis in Court

- Very similar to schizophrenia presentation.
- Alcohol withdrawal delirium (the DT's) occurs 3-4 days after the last drink:
  - Visual and tactile hallucinations
  - Medical emergency
- Look for a history of drug-related arrests.
  - But substance abuse is very common in people with serious mental illness!

Treatment of Drug Psychosis

- Antipsychotic medication is often useful.
  - Alcohol DT's must be treated in a hospital.
- Duration of symptoms is often short, lasting until the intoxication or withdrawal is over.

Antisocial Personality

- An adult who, since the age of 15, has shown a persistent disregard for and violation of the rights of others, based on:
  - Repeated criminal behavior
  - Lying and deceit for personal profit or pleasure
  - Repeated fights or assaults
  - Reckless disregard for safety of self or others
  - Irresponsibility
  - Lack of remorse

Antisocial Personality

- Predominantly male (3:1)
- Very good at manipulating others, usually consciously
- Often abuses drugs and/or alcohol
- High prevalence in jails and prisons
- Some tendency to ‘burn out’ in middle age

Antisocial Personality in Court

- Likely to be familiar with court procedure.
- Can be very pleasant and charming, but unlikely to admit responsibility for actions.
- Some potential for outbursts if young and brash.

Treatment of Antisocial Personality

- There is no psychiatric medication for this disorder.
  - Medications can be helpful for co-morbid psychiatric disorders.
- Psychotherapy is contra-indicated.
  - It’s bad for the therapist.

Borderline Personality

- People who are stably unstable:
  - Poor sense of self-identity
  - Unstable and intense relationships, alternating between idealization and devaluation
    - Black and white thinking
  - Self-injurious behavior
  - Unstable mood, with rapid changes
  - Impulsive behavior

Borderline Personality

- Predominantly female (3:1)
- Turbulent lives at home, work and school
- Very good at manipulating others, often unconsciously
- Often abuses drugs and/or alcohol
- History of being abused as a child is common
- Often in some form of treatment

Borderline Personality in Court

- May be dramatic and overemotional, unpredictable and volatile
- May be involved in domestic disturbances

Treatment of Borderline Personality

- People with borderline personality often have symptoms of depression and anxiety and have unstable moods.
  - Treatment with antidepressant, antianxiety and mood-stabilizing medications is common
- Psychotherapy is the preferred treatment
  - Dialectical behavior therapy

Conduct Disorder

- The junior version of antisocial personality:
  - 12 months of a persistent pattern of violating rules and/or the rights of others by
    - Being aggressive to people or animals
    - Destroying property
    - Stealing from or conning others
    - Violating rules at home or school

Conduct Disorder in Court

- Likely to be in court for stealing, fighting, vandalism or cheating someone.
- Less likely to show remorse than most juveniles.

Treatment of Conduct Disorder

- More amenable to treatment than antisocial personality:
  - Kids are more adaptable and less stubborn than adults!
  - Counseling and consistent, supportive home and school environment that holds the juvenile accountable but teaches alternate coping skills

Oppositional-Defiant Disorder

- A pattern of negative, hostile, and defiant behavior lasting at least 6 months:
  - Often loses temper, easily annoyed
  - Argues with and defies adults
  - Deliberately annoys others
  - Blames others for mistakes and behaviors
  - Resentful, vindictive

Oppositional Defiant in Court

- Likely to be in court for truancy or other school problems and not for fighting or destructive behavior.
- Will be defiant nevertheless!

Treatment of Oppositional Defiant

- Similar to conduct disorder, but somewhat less difficult (less delinquent behavior):
  - Counseling
  - Consistent and fair application of rules

ADHD

- 6 months of symptoms of:
  - Inattention:
    - Careless mistakes, difficulty organizing, easily distracted, often loses things, does not finish projects.
  - Hyperactivity and impulsivity:
    - Fidgety, moves about when expected to be still, talks excessively
    - Interrupts, blurts out answers, can’t wait his turn

ADHD in Court

- Unlikely to be able to wait patiently, pay attention or follow what is happening in court.
- May disrupt proceedings by speaking out of turn or moving around the court.

Treatment of ADHD

- Medications can be helpful:
  - Stimulants
  - Atomoxetine
- Behavioral strategies are very important for all children with ADHD and may be sufficient
  - Consistency between home and school is key

Questions?

Judges' Options

- Diversion programs
  - Pre-arrest: CIT teams
  - Pre-conviction: referral for treatment
  - Post-conviction: treatment requirement
- Civil commitment
- Competence to stand trial
- Not guilty by reason of insanity

Rationale for Diversion

- Many defendants have a mental illness.
  - Particularly in misdemeanor court
- Many of the charges against mentally-ill defendants are related to the mental illness.
  - Substance abuse
  - Disorderly conduct, misdemeanor assault, resisting arrest
  - Trespassing

Rationale for Diversion

- The symptoms of serious mental illness often make it difficult to:
  - Find and keep a job
  - Maintain housing
  - Cope with stressful situations
  - Resist the temptation of substance abuse

Rationale for Diversion

- Medication and community support services can be very effective in helping people live with mental illness.
  - But medications have side effects and are rarely 100% effective in relieving symptoms,
  - People do not want to admit that they have a mental illness (poor insight and/or stigma),
  - And community services are overstretched.

Rationale for Diversion

- It’s not that difficult for mental illness to become active, which may lead to inappropriate behavior and a call to police.
  - From family, friends, neighbors, treatment providers or people on the street.

Pre-Arrest Diversion

- Crisis intervention training (CIT) for police prepares officers for the challenges of resolving calls involving mental illness.
  - Started in Memphis, TN
  - Indiana training has been done in collaboration with NAMI-Indiana
  - Active teams in Indianapolis, Fort Wayne and other cities.

Pre-Arrest Diversion

- CIT educates officers to recognize signs and symptoms of mental illness and provides techniques to handle situations without escalation.
  - Fewer confrontations (and bad outcomes)
  - Fewer arrests
  - More referrals for urgent psychiatric evaluation and treatment

Pre-Conviction Diversion

- Mental health courts have become more common in recent years, especially after federal legislation in 2000 encouraging their development.
- Marion County has perhaps the oldest such program in the country.
  - Psychiatric Assertive Identification and Referral (PAIR) program.

Pre-Conviction Diversion

- There is no standard model for a mental health court, as each court tends to develop in response to individual judges, communities and circumstances.
  - Rules and procedures are often unwritten
  - Reliant on local treatment resources
  - Differing degrees of coercion

Pre-Conviction Diversion

- PAIR program pre-requisites:
  - Serious mental illness
  - Non-violent offense
  - Prosecutor approval
- For one year, the defendant must agree to:
  - Engage in treatment
  - Not commit another offense.
- If successful, the charges are dropped

Post-Conviction Diversion

- Diversion from jail or prison.
- Mental health treatment can be a condition of probation.
  - Requires close coordination between probation and mental health treatment team
- Community Corrections designates certain slots for people with mental illness.

Civil Commitment

- A person who is “alleged to be mentally ill and either dangerous or gravely disabled” may be civilly committed.
  - Mentally ill: having a “psychiatric disorder that (A) substantially disturbs an individual's thinking, feeling, or behavior; and (B) impairs the individual's ability to function.
    - Includes mental retardation, alcoholism, and addiction
  - Dangerous: risk of harm to self or others.
  - Gravely disabled: unable to provide essential needs or function independently.

Civil Commitment

- Can be initiated by
  - A police officer:
    - Immediate detention (24 hours)
  - Others, with physician support:
    - Emergency detention (3 days)
  - A hospital or community mental health center
    - Temporary commitment (90 days)
    - Regular commitment (up to 2 years)

Competence to Stand Trial

- An individual's right to be competent to stand trial goes back to at least 17th century England, when a refusal to enter a plea prevented a trial from proceeding.
  - Question for the 17th century forensic evaluator: 'Mute by malice' or 'mute by God'?
    - Evaluation by pressure (literally).

Current U.S. Standard

- Whether a defendant “has sufficient present ability to consult with his attorney with a reasonable degree of rational understanding and a rational as well as practical understanding of the proceedings against him.”
    - Dusky v. U.S., 1960

The Dusky Standard

- Focuses on current capacity.
- Is a two-pronged test:
  - Strictly cognitive: the nature and objectives of criminal proceedings.
  - Cognitive and volitional: the ability to assist one's attorney.
- Has flexible criteria.
- By preponderance of the evidence.
    - Cooper v. Oklahoma, 1996.

Indiana Statute

- "If at any time before the final submission of any criminal case to the court or the jury trying the case, the court has reasonable grounds for believing that the defendant lacks the ability to understand the proceedings and assist in the preparation of his defense, the court shall immediately fix a time for a hearing to determine whether the defendant has that ability."
  - (IC 25-26-3-1(a))

Request for Evaluation

- The threshold for requesting a competence evaluation is not high:
  - The trial court must order an evaluation if "bona fide doubt" exists regarding competence.
    - Pate v. Robinson, 1966
  - There are "no fixed or immutable signs" that indicate a lack of competence.
  - Repeated evaluations may be appropriate.
    - Drope v. Missouri, 1975

Attorney Referral

- Attorneys doubt the competence of 10-15% of their criminal clients, but less than half of these are referred for evaluation.
    - Hoge et al, 1992; Poythress et al, 1994
- In more than 95% of cases, the primary reason for referral was a serious mental disorder that impaired communication between the defendant and the attorney.
    - Miller and Kaplan, 1992

Indiana Statute

- Prior to the hearing, “The court shall appoint two (2) or three (3) competent, disinterested: (1) psychiatrists; or (2) psychologists… At least one (1) of the individuals appointed under this subsection must be a psychiatrist.”
  - However, the pre-trial evaluator cannot be a state hospital psychiatrist.

Competence Evaluations

- The most common format is the clinical interview.
- The most practical format is the semi-structured interview.
  - All of the elements of competence should be individually assessed during the interview.

Dusky in Practice

- Understanding of proceedings:
  - What are the charges?
  - What are the meaning and consequences of possible pleas?
  - What are possible penalties if found guilty?
  - What are the roles of typical court participants?
  - What are typical court procedures?
  - What's the outcome going to be?

Dusky in Practice

- Ability to assist one's attorney:
  - What's a plea bargain?
  - Do you and your attorney understand each other?
  - Can the defendant testify effectively?
  - What are witnesses supposed to do?
  - Can the defendant comprehend legal advice?
  - Is there any self-defeating attitude?

Outside Sources

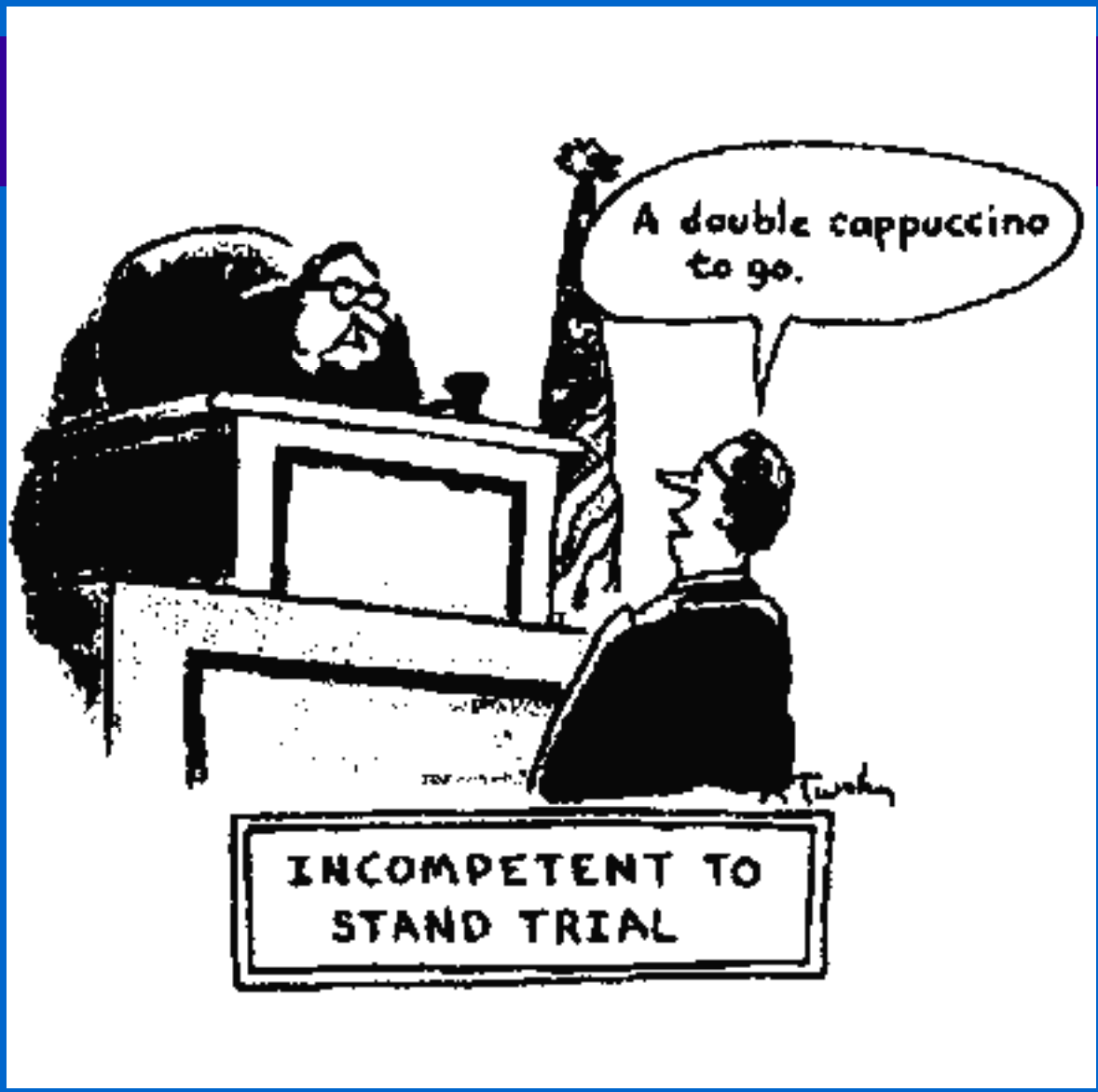
- The evaluator should consider contacting collateral sources:
  - The defense attorney or the judge.
    - Why was the evaluation requested?
  - Family or friends.
    - Verify history, especially cognitive deficits.

The Competence Report

- The background section should include:
  - The reason for referral.
  - A statement of non-confidentiality.
  - Information about the defendant's personal history.
  - A thorough mental status examination.
  - The defendant's psychiatric history.
  - The diagnosis, supported by an explanation.

The Competence Report

- The competence section of the report should include:
  - A review of the defendant's answers regarding each element of the nature and objectives of the proceedings.
  - An assessment of the defendant's ability to meet each of the elements of assisting his/her attorney together with the basis for the findings.


A double cappuccino to go.
INCOMPETENT TO STAND TRIAL

Outcomes of Evaluations

- 10-30% of defendants who are evaluated for competence are found incompetent to stand trial.
    - (Melton et al, 1997)
- Defendants with symptoms of psychosis, limited intelligence, or a history of prior mental health treatment are at highest risk of being found incompetent.
    - (Hoge et al, 1997)

What Happens Next?

- “If the court finds that the defendant lacks this ability, it shall delay or continue the trial and order the defendant committed to the division of mental health and addiction.”
  - IC 35-35-3-1 (b)

Restoration Programs

- Indiana, like many states, does not have a specialized program or a standard curriculum for restoration to competency.
- Defendants are sent to the state hospital with an available bed.
  - A large majority are sent to Logansport State Hospital (LSH), which is the only state hospital with an organized restoration program.

Duration of Restoration

- Incompetent defendants can be held in a state hospital only for: “a reasonable period of time necessary to determine whether there is a substantial probability that he will attain the capacity in the forseeable future.
  - Jackson v. Indiana, 1972

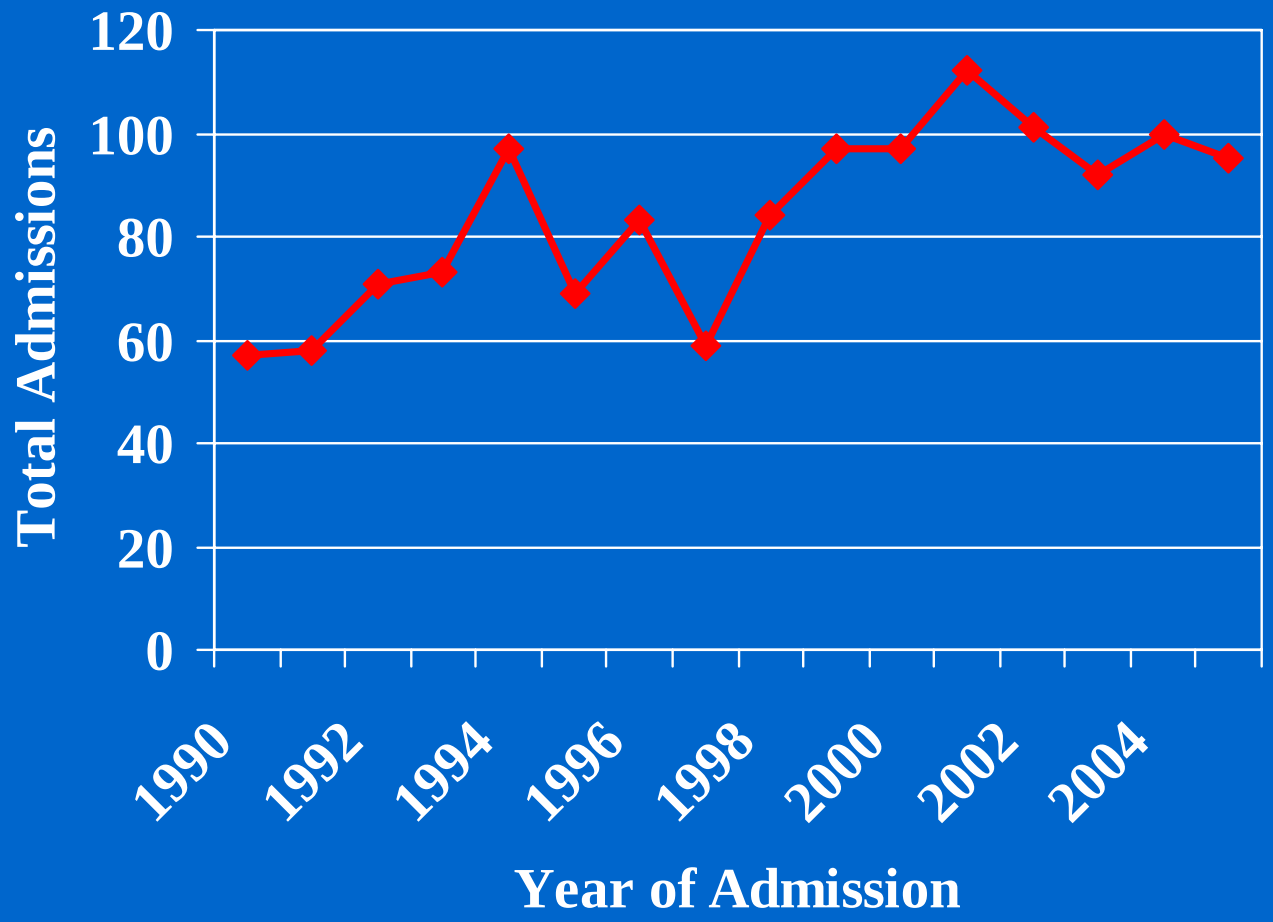
Restoration in Indiana

- The state hospital must report to the court at 90 and 180 days after admission for restoration.
- If the hospital states that a substantial probability of attaining does not exist, DMHA “shall initiate regular commitment proceedings under IC 12-26.”

Referrals for Restoration

- From 1988 to the present, the number of commitments to the Indiana DMHA for the purposes of restoration to competence has increased from 60 per year to about 100 per year.
  - 23 thru February 2006.

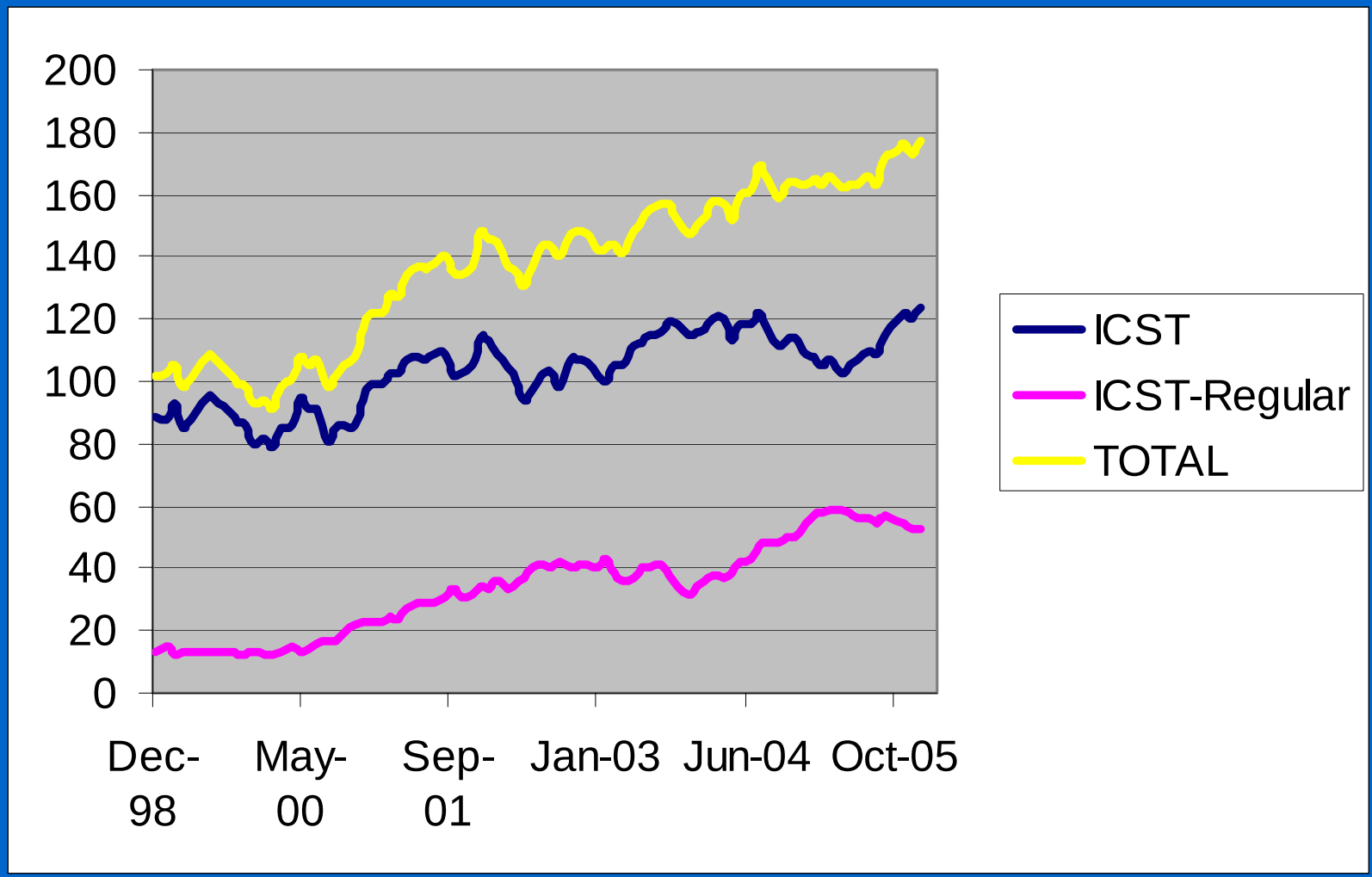
Annual Restoration Admissions



Current Restoration Census

- At the end of February 2006 DMHA had:
  - 124 ICST, including 71 at LSH.
  - 53 ICST-regular commitment, including 32 at LSH.
- Over the past two years, the daily census of incompetent defendants in the hospital has increased nearly 50%.
- The longest current LOS is just over 27 years.

Indiana Restoration Census



Restoration Length of Stay

- The mean LOS has increased over time:
  - 1988-1990: LOS = 187 days
  - 2004: LOS = 204 days

Outcome of Restoration

- In the late 1980's, 10-15% of referrals had a length of stay of more than 200 days.
- Since 2000, 20-25% of defendants referred for restoration had a length of stay of more than 200 days.
  - 2004: 25 of 100 defendants

Unrestored Defendants

- Their fate varies from state to state.
  - Charges may be dismissed.
  - Continued civil commitment may be an automatic result.
    - Open-ended duration
    - Fixed period with dismissal
      - Felony vs. misdemeanor
      - Conditional release

Return to the Community

- For an unrestored incompetent defendant to leave the hospital in Indiana:
  - He must be clinically stable and
  - Either the prosecutor drops the charges or the hospital certifies competence and the patient returns to court to stand trial.

Special Competence Issues

- Juvenile competence to stand trial.
- Competence to waive Miranda rights.
- Competence to waive counsel.

Juvenile Competence

- Current Indiana statute makes no mention of juvenile competence.
- The issue has come up only rarely.
  - Juveniles felt to be incompetent have been restored on an outpatient basis, or the charges were dropped upon referral for services.

Juvenile Competence

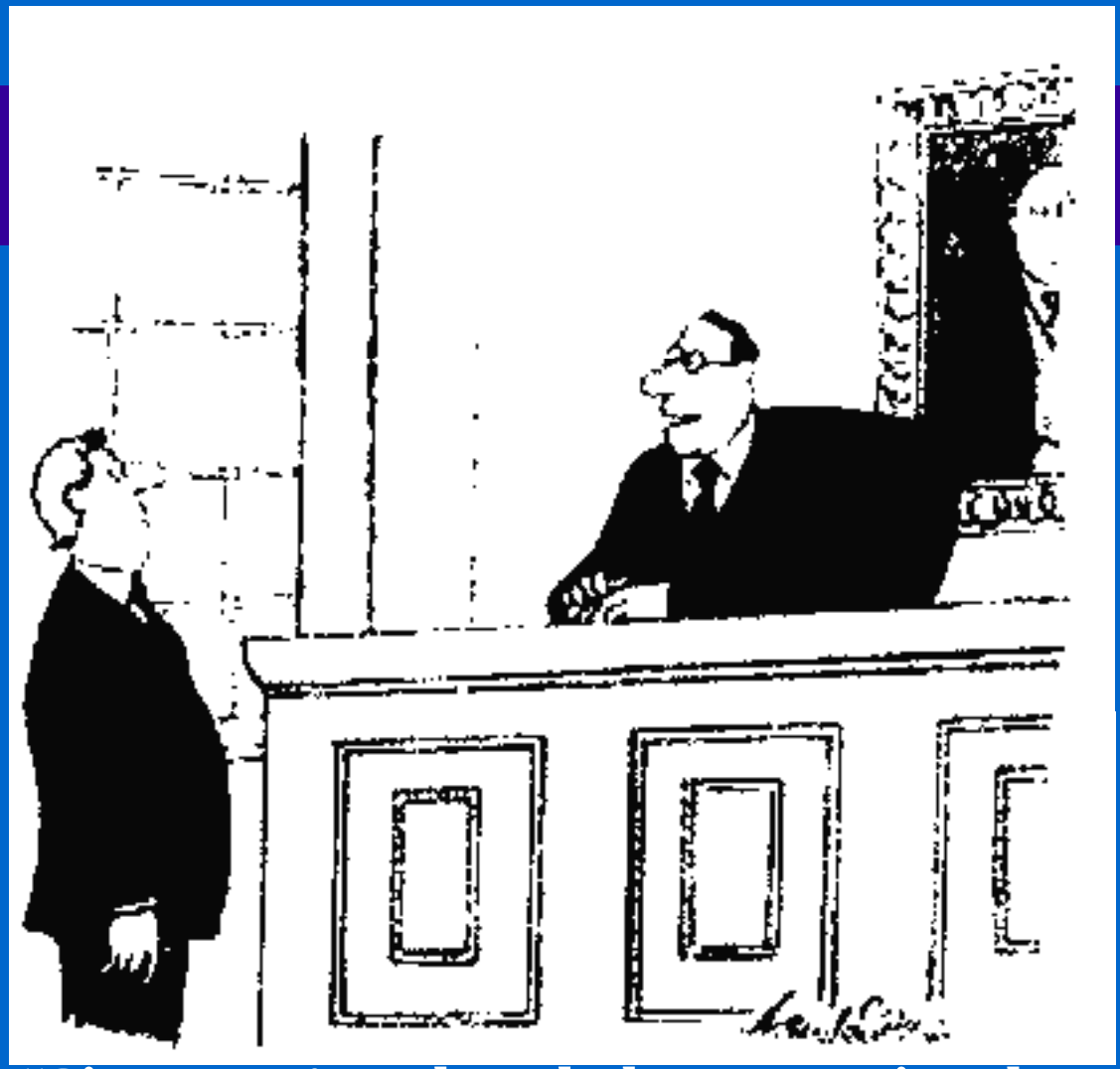
- Research has shown three common reasons for juveniles to be found incompetent:
  - Age (or immaturity)
  - Mental illness
  - Mental retardation
- A large study found that between one in three and one in five juveniles are likely to be incompetent to stand trial, depending on age.
  - Grisso, 2003.

Waiver of Miranda Rights

- The U.S. Supreme Court once required confessions to be voluntary.
  - Bram v. U.S., 1897
- Current standard is whether the defendant's waiver was 'competent and intelligent' and whether coercive police activity led to the confession.
  - Colorado v. Connelly, 1986

Competence to Waive Counsel

- The standard for waiving the right to counsel at trial is the same as the standard for competence to stand trial.
  - Godinez v. Moran, 1993



“Since you’ve already been convicted by the media, I imagine we can wrap this up pretty quickly.”

Not Guilty by Reason of Insanity

- An affirmative defense used for centuries.
- Its application has evolved over time.
- Changes in its use have often come from dramatic, high-profile cases.

The McNaughten Case

- The high-profile British case (1843).
- The NGRI finding, after a high-profile trial, provoked massive public outrage.
- The House of Lords then questioned the Supreme Court of Judicature regarding the insanity defense.

The McNaughten Standard

- “it must be clearly proved that, at the time of committing the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act…or, if he did know it that he did not know he was doing what was wrong.”

The American Law Institute Test

- “A person is not responsible for his criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law.” (1955)

The ALI Test

- Incorporated into the Model Penal Code.
- Subsequently adopted by most Federal circuits and many states.
  - Adopted by the Indiana court in 1969 and by the legislature in 1977.
- There are two prongs to the test:
  - Right-wrong.
  - Volitional.

The Kiritsis Case

- The high-profile case in Indiana (1977).
- The NGRI finding, after a high-profile trial, prompted public outrage.
- Followed by two more high-profile cases:
  - Lyman Bostock murder (1978).
    - Defendant found not guilty by reason of insanity.
  - Chasteen family murder (1979).
    - Defendant pleaded insanity, but was found guilty.

“How do you plead? Please listen carefully, as the menu has changed.”

Indiana Insanity Defense Reform

- The insanity statute was amended in 1978:
  - The burden of proof placed on the defendant.
    - IC 35-41-4-1
- The guilty but mentally ill (GBMI) verdict was added to the insanity statute in 1981.
  - A new option for verdicts in all insanity cases.
  - Judges must sentence those found GBMI as though they had been found guilty.
    - IC 35-36-2-3 & 5

Current Indiana Standard

- "A person is not responsible for having engaged in prohibited conduct if, as a result of mental disease or defect, he was unable to appreciate the wrongfulness of the conduct at the time of the offense."
  - IC 35-41-3-6

Recent Changes

- Amended in 2004 to state that a defendant may not refuse a court-ordered examination if he has undergone an evaluation by a defense expert. If he refuses, the defense expert may not testify.
  - Unless the refusal is shown to be due to the defendant's mental illness.
    - IC 35-36-2-2

Recent Changes

- If a defendant is found NGRI, the state hospital must file reports every six months with the committing court and must notify the committing court prior to unsupervised off-grounds passes, transfer to another state hospital, or discharge.
  - IC 12-26-15-1

State Reforms after Hinckley

- Four states eliminated the defense:
  - Idaho, Utah, Nevada & Kansas joined Montana.
- 34 states revised the insanity standard.
  - 10 states eliminated the ‘volitional arm’.
- 11 states added GBMI as a possible verdict.
  - Joining Michigan (1975) and Indiana.

State Reforms after Hinckley

- 31 states altered post-trial procedures to prevent any rapid return of NGRI acquittees to the community.
  - Mandatory commitment terms.
  - Conditional release programs.
- Indiana does not have conditional release

The Sanity Evaluation

- All sanity evaluations are, by definition, retrospective in nature.
- The sooner the evaluation, the better.
- Collateral information is very important.

The Sanity Evaluation

- The clinical interview in a sanity evaluation should focus on the defendant's recall of the events preceding, during and following the offense.
- The defendant's narrative, along with the collateral information, forms the database for the assessment of appreciation of wrongfulness.

The Sanity Report

- The report should include the database, preferably in detail, on which the opinion rests.
- The opinion should be explicitly based on the database.

Use of the NGRI Defense

- Raised in only ~1% of felony cases.
- Successful in only ~25% of attempts.
- Nearly 90% of NGRI verdicts occur without a trial and are based on a plea agreement.
- Juries rarely find a defendant NGRI, particularly for violent offenses.

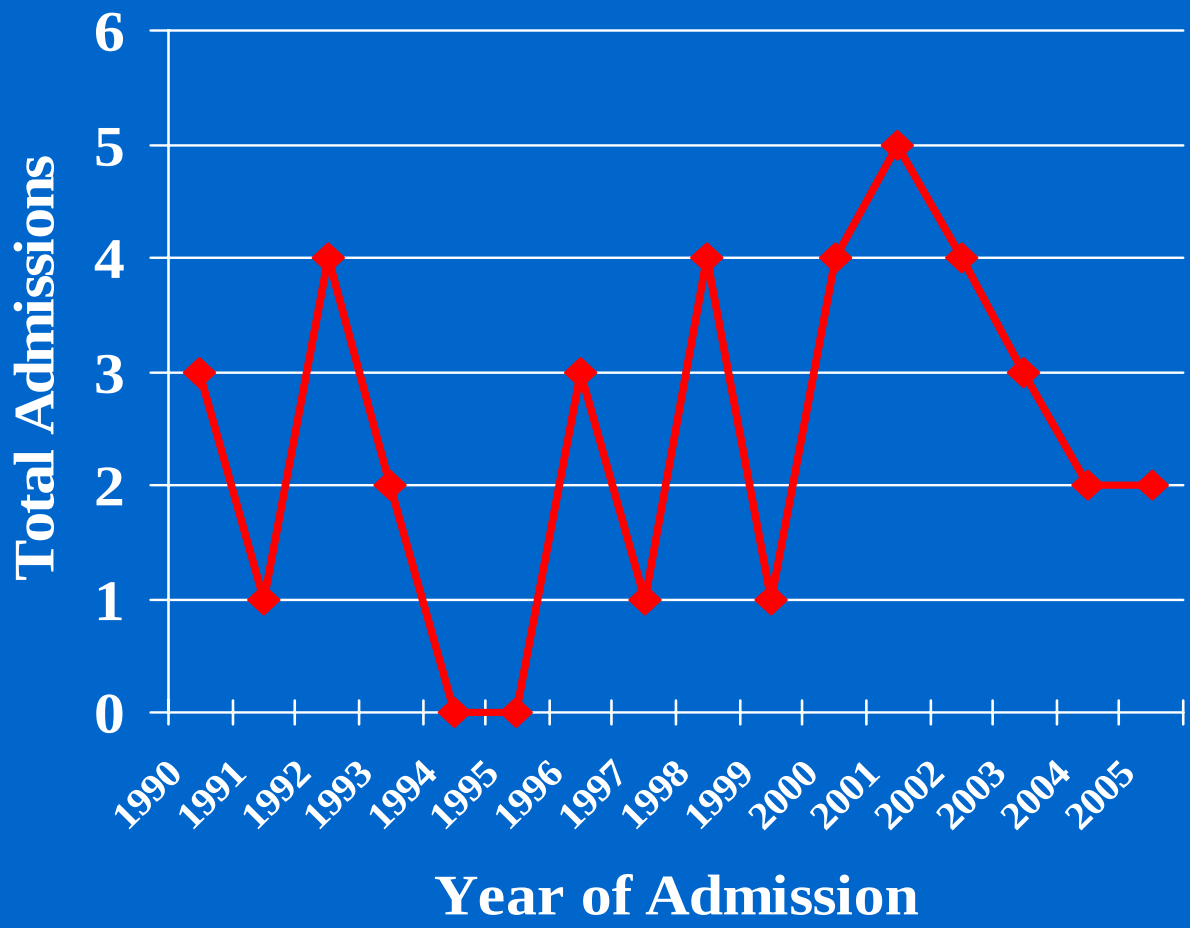
Who is Found NGRI?

- Defendants with psychotic disorders:
  - Schizophrenia.
  - Mania.
  - Delusional disorder.
- Defendants charged with violent crimes.
  - Predominantly, but not exclusively.
  - Depends on the state and the NGRI standard.

After the NGRI Verdict

- The court must determine whether the acquittee meets civil commitment criteria.
- NGRI acquittees may not be held unless they are both mentally ill and dangerous.
  - Foucha v. Louisiana, 1992

Annual NGRI Admissions



Indiana NGRI Length of Stay

- In general, the more severe the offense, the longer the hospital stay.
  - Indiana has no maximum duration.
  - Several states limit the total time to the maximum sentence for the offense.
- As of February 2006, there were six patients in Indiana state hospitals with the legal status of NGRI.
  - LOS is 4-5 years for three acquittees, 27 years for one.

Return to the Community

- The acquittee's mental illness must be stable.
- Potential dangerousness must be limited.
- The criminal court has a limited role in the discharge process.
  - It may be notified of intent to discharge.

Mental Illness and Violence

- Overall, the risk of violence among people with mental illness is the same as the risk among people without mental illness.
  - IF the mental illness is effectively treated!
  - People with mental illness are more likely to be the victims, rather than the perpetrators, of violence.
- The risk increases if the person is not in treatment or is actively using drugs or alcohol.

Firearms and Mental Illness

- In 2005, in response to the deaths of two Indianapolis police officers, the legislature passed a law allowing the state to retain firearms, even if no charges are filed, if the possessor is proved to be dangerous by clear and convincing evidence.
    - IC 35-47-13-6

Firearms and Mental Illness

- Dangerous is defined as:
  - Presents an imminent risk of injury to self or others, or
  - Presents a future risk of harm to self or others and
    - The person has a mental illness that can be treated with medication and a pattern of not taking this medication consistently, or
    - There is evidence that the person has “a propensity for violent or emotionally unstable conduct.”

Firearms and Mental Illness

- Cases to date:
  - People with mental illness who have threatened violence or suicide
  - Domestic violence
  - Immediate detentions
- Major procedural issue: first hearing should be conducted in 14 days by statute.
  - Legislative revision?

Thank you